Patient Information as of _____
(Please print legibly and fill in or correct all fields)

Title: Dr. _____ **Mr.** _____ **Mrs.** _____ **Ms.** _____ **Miss.** _____ **Other:** _____

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail _____

Age _____ Birthdate _____ SS# _____ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Out of State Address: _____
Street & Apt # City State Zip

Out of State Phone _____

Patient's Employer _____ Occupation _____

Work Phone: _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address: _____
Street & Suite # City State Zip

Primary Health Insurance Company _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____
Primary Card Holder: Name _____ DOB _____ SS# _____

Secondary Health Insurance Company _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, _____
Primary Card Holder: Name _____ DOB _____ SS# _____

Emergency Contact: Relationship: _____

Name: _____ Phone: _____

Family Physician's Name: _____ Phone: _____

Referring Physician's Name: _____ Phone: _____

Do we have your permission to:

Leave a message on your answering machine at home? ☐ No ☐ Yes

Leave a message at your place of employment? ☐ No ☐ Yes

Discuss your medical condition with any member of your household? ☐ No ☐ Yes

If yes, whom: _____ Relationship: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Apollo Beach Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manneunderstand that my contract is between Dr. David Sax and myself. I understand that my contract is between Dr. David Sax and myself. Apollo Beach Dermatology has a 24 hour Cancellation policy. **A $25.00 Cancellation fee will be charged to patients who do not contact the office to cancel or reschedule.**

Signature _____ **Date** _____

Patient Name: **Date:**

Are you interested in any of the following:

___ BOTOX® Cosmetic (Botulinum Toxin Type A)
___ Dermal Fillers (Juvederm, Restylane)
___ Sculptra
___ Thermage
___ Skin Rejuvenation
___ Retin-A / Tretinoin or Renova
___ Micro- Dermabrasion
___ Acne
___ Chemical Peels
___ Other, please specify_____

___ Skin Care Advice
___ Skin Care Products
___ Birthmarks
___ Liver spots / Age Spots / Brown Spots
___ Sunscreen Advice
___ Fat Reduction (CoolSculpting)
___ Facial and Eye Treatments
___ Hair Removal
___ Laser Treatments

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of aging.

Not Concerned *Somewhat Concerned* *Very Concerned*

1 2 3 4 5

How did you hear about us?

___ My physician (full name) _____
___ My insurance company provider (name) _____
___ The yellow pages (specific advertisement) _____
___ A friend or family member (name) _____
___ Another person not listed above (name) _____
Please provide the name and address of the person who referred you so we can thank them.
_____
___ Internet (name) _____
___ A seminar where I saw the doctor (name of event) _____

We want to Thank You for taking the time to fill out this Questionnaire.

DERMATOLOGY MEDICAL HISTORY

Today's Date:

Patient Full Name: _____ **Date of Birth:** _____ **Age:** _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO **Are you allergic to any food?** ☐ YES ☐ NO If yes, list below:
1. _____ 3. _____
2. _____ 4. _____

Have you ever had dental anesthesia (Novocain)? ☐ YES ☐ NO **Any bad reaction?** ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions and over-the-counter meds.)
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: ☐ YES ☐ NO If yes, check boxes below:

Asthma / Bronchitis / Emphysema	☐ YES	List details: _____
Arthritis	☐ YES	List details: _____
Blood Clots / Varicose Veins	☐ YES	List details: _____
Breast Cancer	☐ YES	List details: _____
Cardiovascular Complaints	☐ YES	List details: _____
Cancer	☐ YES	List details: _____
Chest Pain / Tightness	☐ YES	List details: _____
Diabetes	☐ YES	List details: _____
Epilepsy / Seizures / Convulsions	☐ YES	List details: _____
Fibromyalgia	☐ YES	List details: _____
Hepatitis	☐ YES	List details: _____
High Blood Pressure	☐ YES	List details: _____
Kidney Disease	☐ YES	List details: _____
Pacemaker	☐ YES	List details: _____
Skin Condition	☐ YES	List details: _____
Skin Cancer	**☐ YES**	**List details:** _____
Skin Disease	☐ YES	List details: _____
Stroke	☐ YES	List details: _____
Thyroid Disorder	☐ YES	List details: _____
Tuberculosis	☐ YES	List details: _____
Ulcers / GI Complaints	☐ YES	List details: _____

List any other diseases or conditions: _____

Do you smoke? ☐ YES ☐ NO If YES, how much? _____

List any MAJOR surgical procedures you have ever had: _____

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day
Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____
Do you have any STDs ☐ YES ☐ NO If YES _____

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

List all vitamins or minerals you currently taking:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Has anyone in your family had skin cancer? ☐ YES ☐ NO If YES who and what kind _____
Do you have problems with healing / scars? ☐ YES ☐ NO If YES please explain _____
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin
☐ Other _____
Please list the pharmacy you would like us to use:

_____
Pharmacy Name Pharmacy Phone # Pharmacy Address

Please answer the following questions:
(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ____/____/____

Patient's or Guardian's Signature: _____ **Date:** _____